STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155490	A. BUILDING _____ B. WING _____	03/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTHCARE LLC	705 EAST MAIN STREET CENTERVILLE, IN47330

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F0000	This visit was for the Investigation of Complaint IN00087129 and IN00088084. This visit resulted in partially extended survey - substandard quality of care - immediate jeopardy. Complaint IN00087129 substantiated, federal/state deficiencies related to the allegations are cited at F 224 Complaint IN00088084 substantiated, federal/state deficiencies related to the allegations are cited at F224. Survey dates: March 21, 22, and 23, 2011 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Survey team: Barbara Gray RN TC Sharon Lasher RN (March 23, 2011) Angel Tomlinson RN (March 23, 2011) Census bed type: SNF: 2 SNF/NF: 111 Total: 113 Census payor type:	F0000	By submitting the enclosed materials, we are not admitting the turth or accuracy of any specfic findings or allegations as of these responses pursauant to our regulatory obligations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 13 Medicaid: 89 Other: 11 Total: 113 Sample: 3 Supplemental Sample: 2 This deficiency also reflects state findings in accordance with 410 IAC 16.2 Quality review completed 3-24-11 Cathy Emswiller RN			

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F0224 SS=J	Based on observation, interview, and record review, the facility failed to ensure 1 resident was not neglected in that the facility failed to supervise a dependent resident who was left on the facility bus after returning from a dental appointment for approximately 5 1/2 hours before being taken into the facility. This affected 1 of 3 residents in a sample of 3 and an supplemental sample of 2. (Resident #A) An Immediate Jeopardy (IJ) was identified on 3/22/11. The IJ began on 3/2/11, when resident #A was left on the facility bus for approximately 5 1/2 hours after returning from a dental appointment. The facility failed to have a check system in place to ensure residents were returned safely to the facility after an appointment, and establish communication procedures among staff to determine a residents whereabouts. The Administrator, and Director of Nursing (DoN) were notified of the IJ on 3/22/11 at 5:00 P.M. The IJ was removed on 3/23/11, but the facility remains out of compliance at a level of isolated, no actual harm with the potential for more than minimal harm that is not immediate jeopardy, because all staff had not been inserviced, and the need to incorporate policies into one policy. Findings include:	F0224	1. The Administrator and D.O.N. were immediately notified of the incident on 3/2/2011. At that time Carl Basford was called by Maintenance Supervisor, Greg Masters and Administrator Denna Masters and was suspended immediately pending investigation. A thorough investigation began immediately with interviews of resident and staff.2. Mr. Basford was terminated on 3/3/2011. Upon interviews with nursing staff and resident there was no prior incidences of any kind with Mr. Basford. All residents will receive proper transport via facility bus per facility policy.3. The systemic changes includes training of all Nursing staff, Maintenance staff, Laundry staff and Activity staff. Training includes In-Service on 3/3/2011 on updated policy and procedure on transporting of residents and documentation needed related to transports. (See attachment A) The 3/3/2011 Policy & Procedure was updated with more detail again on 3/23/2011 and staff are being In-Serviced on the updated policy 3/23/2011. The ISDH ask that we combine the 2 policies into one policy on3/23/2011. (See attachment B) All modes of transportation (family, ambulance, city care van, facility bus, ETC) will notify the nurse in charge that they are taking the resident. The nurse will provide the Release of	04/08/2011

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	Resident #A was observed seated in his wheelchair in the hallway on 3/21/11 at 2:10 P.M. Resident #A had his right leg amputated above the knee, and all 4 fingers on his right hand. During interview at that time, Resident #A indicated he recalled being left on the facility bus. Resident #A indicated he had been to the dentist and picked up his bottom dentures. Resident #A indicated he fell asleep on the facility bus, and when he woke up his hands were cold. Resident #A's record was reviewed on 3/21/11 at 2:25 P.M. Resident #A's March, 2011 physician's recapitulation order indicated Resident A's diagnoses included, but were not limited to, Alzheimer's dementia, polyarthritis, high fall risk, hypertension, chronic urinary tract infection, benign prostate hypertrophy, pelvic cancer, bone cancer, visual hallucinations, and auditory hallucinations. Resident #A's quarterly Minimum Data Set (MDS) assessment dated 12/12/10, indicated Resident #A was able to make himself understood, and had the ability to understand others. He required extensive assist of 1 person for bed mobility, transfer, dressing, toilet use, and personal		Responsibility for Leave of Absence Form (Attachment C) to the transporter to sign out resident. The nurse will document in the nurses notes destination and mode of transport. The nurse will document on the 24 hour report the destination and mode of transport. The transporter will give any paperwork to the nurse upon return to the resident to the facility. Upon returning the resident to the facility the nurse will sign the resident back into the facility via the Release of Responsibility for leave of Absence form. If at anytime the resident is not returned to the facility in a timely fashion, the nurse will call the family or the destination to ensure that there has been no issues. I/e Appointment ran late, transport hasn't arrived, or family has decided to keep for a longer period of time. The nurse will make a notation on the 24 hour report the reason for the resident not being returned to the facility in a timely fashion, so on coming shift is aware of situation. When the facility bus is used to transport resident to activity or appointment, the driver will do a walk through after each transport to ensure that no items have been left and that all residents are off the bus. The driver will sign off the bus check form, located on a clip board located on the bus. (See attachment D) The laundry	

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	hygiene. Nurses notes for resident #A indicated the following: 3/2/11 at 9:20 P.M. - The resident has not returned from a dental appointment from earlier today on day shift. 3/2/11 at 9:45 P.M. - The resident was found sitting in the bus after his dentist appointment. The resident was brought back into the facility, put to bed, and covered. Skin assessment done and no open areas noted. Buttock area red. B/P 160/86, temperature 96.4, pulse 80, respirations 20, and oxygen saturation 95%. Respirations easy and non-labored. Resident is alert and responsive. No complaint voiced. No documentation was available in the nurses notes that Resident #A had left the facility, and with whom Resident #A had left the facility with. Review of the facility's investigation on 3/21/11 at 10:55 A.M., indicated the following: Brief description of Incident - The resident was found on the facility bus after his dentist appointment. The resident was brought into the facility. The resident was examined and found uninjured. B/P 160/86, tympanic temperature 96.4, pulse 80, respirations 20, and oxygen saturation 95% at room air. Type of injury - Head to toe assessment completed, no injuries found.		staff will do a walk through between 5:00pm and 5:30 pm to ensure that no resident is on the bus. The laundry staff will sign off the bus check form after doing their walk through. The Maintenance Supervisor will provide the Administrator a copy of bus check form weekly. If there are no runs on the weekends, laundry will be the only department required to do the bus check form. In addition, the full staff will complete transportation training on residents using the facility bus at a minimum of yearly and this same training will be provided to all staff during new hire orientation. 4. A 2-step procedure has been put in place to check the bus. Maintenance will check the bus after each run and before clocking out for the day. Laundry will do a check of the bus between 5:00pm & 5:30pm daily as a back up check to ensure that no one is on the bus. The D.O.N. and /or her designee will do daily checks of calendars and check documentation to ensure that notification is available for on-coming shift of who transported the residents, Monday - Friday for 30 days, twice a week for 30 days then random checks monthly. Any issues found will be discussed during the quarterly Q.A. Meeting.5. 4/08/2011	

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	Skin intact with no open areas noted. Buttock bilaterally slightly red but blanched. Immediate action taken - Administrator, DoN, physician, and resident's power of attorney (POA) notified. Complete assessment done with no concerns noted. Bus driver suspended pending investigation Investigation immediately started. Preventative measures taken - The resident has been assessed for psychosocial well being without any concerns noted at this time. Policy put in place with a check off system to ensure that residents are returned to facility. All licensed staff, maintenance, and laundry staff in-serviced on new procedure. Nurses will document on the 24 hour report for shift to shift report when residents are out of the building. The facility investigation indicated an RN realized Resident #A was not back for supper, and by looking at the calendar, thought resident #A was out with family. Written on the calendar was Resident #A's name, and the words family dentistry. At the top of the calendar written in faint writing were the words, arrange facility transportation. Resident #A's appointment card was attached to the desk calendar indicating his appointment was scheduled for 1:30 P.M. The RN indicated when it was close to the end of her shift she called resident #A's POA,			

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	and was informed resident #A was not with him. The RN then called a day shift LPN on his cell phone at 9:31 P.M., and was informed the facility had taken Resident #A to his appointment. At approximately 9:37 P.M., a LPN on evening shift handed an evening shift CNA a flashlight to check the facility bus. The CNA found Resident #A seated on the bus at approximately 9:38 P.M. Resident #A told the CNA to shut the door because he was letting the cold in. The bus driver who transported Resident #A to and from his dental appointment could not recall taking Resident #A back into the facility upon return. An LPN looked the temperature outside up on the Internet. On 3/2/11 at 5:00 P.M., the temperature was 49 degrees and sunny. On 3/2/11 at 9-9:30 P.M. the temperature was 39 degrees. An interview with the Administrator on 3/21/11 at 12:10 P.M., indicated Resident #A was the only resident on the facility bus on 3/2/11. She indicated there was no system in place at that time to double check all residents were off the bus and safely in the facility. An interview with the DoN on 3/21/11 at 4:25 P.M., indicated prior to the incident, staff would fill out a maintenance			

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	transportation request, and place the form in maintenance's mail box. The appointment would be written on the calendar, along with who would be transporting the resident. The DoN indicated no nurses note had been documented on 3/2/11, indicating Resident #A left the facility, and with whom he left with. An interview with the Administrator on 3/22/11 at 5:12 P.M., indicated prior to the incident on 3/2/11, there was no policy on the bus drivers responsibilities related to transporting a resident. An interview with LPN #1 on 3/23/11 at 11:10 A.M., indicated Resident #A left on the facility bus to pick up his dentures on 3/2/11 at approximately 1:15 P.M. LPN #1 indicated he normally documented a nurses noted when a resident left for an appointment with the time, type of appointment, and with whom the resident left with. Resident #A indicated he did not document a nurses note for resident #A on 3/2/11 when he left for his appointment. LPN #1 indicated on 3/2/11, he documented on the shift report, Resident #A was on leave of absence to the dentist, but failed to document how Resident #A was transported.			

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	An interview with RN #2 on 3/23/11 at 2:30 P.M., indicated on 3/2/11 she received in shift report Resident #A had left the facility on day shift for an appointment , and when she glanced at the calendar she thought he was out of the facility with family. RN #2 indicated Resident #A was not in the facility for his evening meal. RN #2 indicated she called Resident #A's nephew when it was getting close to the end of her shift, and was informed Resident #A was not with him. RN #2 indicated Resident #A had been dressed in a shirt, pants, shoes, and jacket while left seated on the bus. RN #2 indicated Resident #A had been incontinent of his bladder while seated on the bus. RN #2 indicated Resident #A's buttock was slightly red with no open areas. A physician's order dated 3/2/11 at 10:10 P.M., indicated to give Resident #A all of his 5:00 P.M., 7:00 P.M., 8:00 P.M., and 9:00 P.M., medications together except his 5:00 P.M., depakote. Resident #A's medication record indicated Resident #A received the following medications on 3/2/11 at 10:10 P.M.: Flomax 0.4 milligram (mg) capsule, pepcid 20 mg tablet, lyrica 150 mg capsule, potassium chloride 20			

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	millequivalents tablet, depakote 500 mg tablet, gabapentin 300 mg capsules (3 capsules), and ultram 50 mg tablet. A weekly skin sweep for Resident #A dated 3/21/11, indicated no open areas. An observation of Resident #A's skin on 3/23/11 at 2:05 P.M., indicated no open areas. The current abuse policy provided by the Administrator on 3/21/11 at 10:42 P.M., indicated the following: Purpose - To ensure that each resident is free of physical, mental, verbal, and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. Policy - Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.... An Immediate Jeopardy (IJ) was identified on 3/22/11. The IJ began on 3/2/11, when a resident was left on the facility bus for approximately 5 1/2 hours after returning from a dental appointment. The facility failed to have a check system in place to ensure residents were returned safely to the facility after an appointment, and establish good communication procedures among staff to determine a residents whereabouts. The			

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	Administrator, and Director of Nursing (DoN) were notified of the IJ on 3/22/11 at 5:00 P.M. The IJ was removed on 3/23/11 at 3:22 P.M., when a through review of the facility's corrective policies, and interview with facility staff inserviced was completed. It was determined the facility implemented the plan of action to remove the IJ and the steps taken removed the immediacy of the problem. Even though the facility's corrective action removed the IJ, the facility remained out of compliance at isolated level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, because all staff had not been inserviced, and the need to incorporate policies into one policy. This federal tag relates to complaint IN00087129 and IN00088084 3.1-27(a)(3)			

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